



## PLAN DESIGN AND BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

	BY AETN	IA LIFE INSURANCE COMP.	ANY	
PLAN FEATURES		RED CARE		FERRED CARE
Deductible (per plan year)	\$200	Employee	\$400	Employee
, ,	\$400	Family	\$800	Family
All covered expenses, excluding prescription dre	ugs, accun	nulate toward both the preferr	ed and nor	-preferred Deductible.
Unless otherwise indicated, the Deductible mus	t be met pr	ior to benefits being payable.		
Members with a Family Deductible do not have	an Individu	al Deductible to satisfy.		
Once Family Deductible is met, all family memb	ers will be	considered as having met the	eir Deductib	ole for the remainder of the
plan year.				
Member Coinsurance	10%		30%	
Applies to all expenses unless otherwise stated				
Coinsurance Limit (per plan year)	\$1,000	Employee	\$3,000	Employee
	\$2,000	Family	\$6,000	Family
All covered expenses, excluding prescription dre	ugs, accun	nulate toward both the preferr	ed and nor	-preferred Payment Limit.
Only those out-of-pocket expenses resulting from	m the appl	ication of coinsurance percer	itage, dedu	ctibles, and copays (except
any penalty amounts) may be used to satisfy the	e Payment	Limit.		
Members with a Family Out-of-Pocket Maximum				
Once Family Coinsurance Limit is met, all family	y members	will be considered as having	met their C	Coinsurance Limit for the
remainder of the plan year.				
Lifetime Maximum				
Unlimited except where otherwise indicated.				
Primary Care Physician Selection	Not appli	cable	Not applic	cable
Certification Requirements -				
Certification for certain types of Non-Preferred of	care must b	e obtained to avoid a reducti	on in benef	its paid for that care.
Certification for Hospital Admissions, Treatment	t Facility Ad	dmissions, Convalescent Fac	ility Admiss	ions, Home Health Care,
Hospice Care and Private Duty Nursing is requ	ired - exclu	ided amount applied separate	ely to each	type of expense is \$300 per
occurrence.			•	
Referral Requirement	None		None	
PREVENTIVE CARE	PREFER	RED CARE	NON-PR	FERRED CARE
Routine Adult Physical Exams/	10% afte	r \$20 office visit copay	30%	
Immunizations				
1 exam per 12 months	10% afte	r \$20 office visit copay	30%	
	10% afte	r \$20 office visit copay	30%	
1 exam per 12 months  Routine Well Child Exams/Immunizations				ns thereafter to age 18.
1 exam per 12 months  Routine Well Child Exams/Immunizations  7 exams in the first 12 months of life, 2 exams in	n the 13th-	24th months of life; 1 exam p	er 12 montl	ns thereafter to age 18.
1 exam per 12 months  Routine Well Child Exams/Immunizations  7 exams in the first 12 months of life, 2 exams in Routine Gynecological Care Exams	n the 13th- Covered	24th months of life; 1 exam p		ns thereafter to age 18.
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Not Covered

Same as preferred care.

Not Covered

10% after \$50 copay

Non-Urgent Use of Urgent Care Provider

**Emergency Room** 

Diagnosis and treatment of the underlying medical condition. place of service where it is rendered place of service where it is rendered 30%  Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.  Advanced Reproductive Technology 10% 30%  ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	Non-Emergency care in an Emergency Room	50%	50%
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay  The member cost sharing applies to all covered benefits incurred during a member's inpatient stay  Outpatient Hospital Expenses (including 10% 30% The member cost sharing applies to all covered benefits incurred during a member's uppatient visit  MENTAL HEALTH SERVICES PREFERED CARE NON-PREFERED CARE Inpatient  Inpatient 10% 30% Mental deductible for 1st 5 visits, 65% after deductible for 6-30ths visits 50% after deductible for 6-30ths visits 50% after deductible for 6-30ths visits 50% after deductible for 6-30ths visits 64% after deductible for 6-30ths visits 64% after deductible for 6-30ths visits 64% after deductible for 6-30ths visits 50% after deductible for 6-30ths visits 64% after deductible for 6-30ths visits 6			
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Inpatient Maternity Coverage The member cost sharing applies to all Covered benefits incurred during a member's inpatient stay  Wing March Hospital Expenses (including a 10% 30% 30% 30% 30% 30% 30% 30% 30% 30% 3		benefits incurred during a member's inp	atient stay
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit MENTAL HEALTH SERVICES PREFERED CARE Inpatient Unlimited. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay Unlimited Unlimited Unlimited Unlimited Now after deductible for 1st 5 visits, 65% after deductible for 6-30ths visits O's after deductible for 6-30ths visits ALCOHOLORUS ABUSE SERVICES PREFERED CARE Inpatient Unlimited 10% Unlimited 10% NoN-PREFERED CARE Inpatient 10% NoN-PREFERED CARE Inpatient 10% Unlimited 10% NoN-PREFERED CARE Inpatient 10% Unlimited 10% NoN-PREFERED CARE Inpatient 10% Unlimited 10% Outpatient 10% Unlimited 10% Outpatient 10% Outpatient 10% NoN-PREFERED CARE Inpatient 10% NoN-PREFERED CARE Outpatient 10% Outpatient 10% NoN-PREFERED CARE 10% NoN-PR			
MENTAL HEALTH SERVICES   PREFERRED CARE	The member cost sharing applies to all covered	benefits incurred during a member's inp	atient stay
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit  MENTAL HEALTH SERVICES  PREFERED CARE  Inpatient  10%  10%  10%  10%  10%  10%  10%  10	Outpatient Hospital Expenses (including	10%	30%
Impatient   10%   30%			
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PHARMACY PREFERRED CARE NON-PREFERRED CARE	DUADMAOV		
	PHARMACY	PREFERRED CARE	NUN-PREFERRED CARE

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Retail	\$10 copay for generic drugs, \$20	\$10 copay for generic drugs, \$20
	copay for formulary brand-name	copay for formulary brand-name
	drugs, and \$35 copay for non-	drugs, and \$35 copay for non-
	formulary brand-name drugs. Up to a	formulary brand-name drugs. Up to a
	90 day supply for 3X the copay.	90 day supply for 3X the copay.
Mail Order	\$10 copay for generic drugs, \$20	Not Covered
	copay for formulary brand-name	
	drugs, and \$35 copay for non-	
	formulary brand-name drugs up to a	
	90 day supply from Aetna Rx Home	
	Delivery®.	

## Pharmacy Managed Self Injectables (PMSI)

First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Speciality Pharmacy®

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

**Plan Includes**: Performance Enhancing Medication, Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Injectable fertility drugs (physician charges for injections are not covered under RX, medical coverage is limited), Diabetic supplies.

Precert for growth hormones included

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 25.
Pre-existing Conditions Exclusion	On effective date: Waived
	After effective date: Full Postponement

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan.

With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not avai

Plans are provided by Aetna Life Insurance Company.

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